

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03739

03729

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Unknown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>128 West Patrick Street</b>		d. STREET ADDRESS <b>128 West Patrick Street</b>	
3. NAME OF DECEASED (Type or print) <b>HENRY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>1</b> Hours <b>1</b> Min.	
11. BIRTHPLACE (State or foreign country) <b>Wilkes Barre, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Price</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK.</b>		16. SOCIAL SECURITY NO. <b>195 09 4702 A</b>	
17. INFORMANT <b>Mrs. Helen B. Welsh, Baltimore, Maryland</b>		Address <b>323 E. 33rd. Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic Heart Diseased</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		22. DATE SIGNED <b>March 22, 1966</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>March 22, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03730 CERTIFICATE OF DEATH					03730				
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route 7</b>					d. STREET ADDRESS <b>Route 7</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daisy M. Anderson</b>			First Middle Last		4. DATE OF DEATH <b>March 23- 19 66</b>		Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 22- 1892</b>		9. AGE (In years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington Co. Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Albright</b>					14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Young</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Sherman W. Clem-Rt. 7- Frederick-Md.</b>			Address <b>21701</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, acute</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis coronary arteries</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>10 years</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1962</b> to <b>March 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 23, 1966</b> , and that death occurred at <b>8 P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>B.O. Thomas Jr.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Mar. 24-1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. B.O. Thomas Jr.</b>					22d. ADDRESS <b>Prof. Bldg.- Frederick-Md. 21701</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Mar. 26-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>	
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son--</b>					ADDRESS <b>Whitmore Frederick, Md. 21701</b>		25a. REC'D BY REGISTRAR <b>MAR 29 1966</b>		
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

100-100000

UNITED STATES OF AMERICA

Department of Justice

Federal Bureau of Investigation

Washington, D.C.

Room 1

Admission

Entry

Personal File

100-100000

Identification

100-100000

Administrative

100-100000

Index



Office

100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Myersville</b> d. STREET ADDRESS <b>Route 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Virginia Grace Bidle</b>						4. DATE OF DEATH <b>March 4 1966</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>w</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/11/1889</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>Philip F. Gaver</b>						14. MOTHER'S MAIDEN NAME <b>Anna E. Hooper</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Walter S. Bidle, Sr., Myersville, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary thrombosis</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>atherosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>March 4, 1966</b> , to <b>March 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 3, 1966</b> , and that death occurred at <b>6:40</b> M, from the causes and on the date stated above.													
22a. SIGNATURE <b>Henry V. Chase</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/4/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>						22d. ADDRESS <b>4 E. Church St Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/6/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Middletown, Md.</b>					
24. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Md.</b>						25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

03781

Virginia Grace Bidle

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March 22

Henry I. Chase

Henry I. Chase



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03742					CERTIFICATE OF DEATH					03732				
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>819 North Market Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>819 North Market Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>IRENE CAMPBELL BISER</b>			First Middle Last		4. DATE OF DEATH <b>March 14, 1966</b>			Month Day Year						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 July 1876</b>		9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>					
13. FATHER'S NAME <b>Charles Walter</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Appel</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Francis R. Biser, Address Maury Ave., Norfolk, Va.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Seriously ill with arteriosclerosis, heart disease</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from <b>11-6, 1964</b> , to <b>3-14, 1966</b> , that (I) (we) last saw the deceased alive on <b>9-14-1965</b> , and that death occurred at <b>1 P</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>Rex R. Martin</b>					M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>15 March 1966</b>						
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>					22d. ADDRESS <b>220 N. Market St., Frederick, Md. 21701</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Middletown, Maryland</b>							
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b>					25a. REC'D BY REGISTRAR <b>MAR 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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1. *Introduction*

W. E. Stebbins, San Francisco, California



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Frederick</b></span>						
<b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				<b>c. LENGTH OF STAY IN 1b</b> <b>Years</b>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>						
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <b>Wynelle Nursing Home</b>						<b>d. STREET ADDRESS</b> <b>324 Park Avenue</b>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>First Middle Last</b> <b>Marian Elizabeth Blentlinger</b>			<b>4. DATE OF DEATH</b> <b>Month Day Year</b> <b>March 7- 19 66</b>			<b>5. SEX</b> <b>Female</b>			<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>August 29-1878</b>			<b>9. AGE</b> (In years last birthday) <b>87 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>					
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick Co. Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>						
<b>13. FATHER'S NAME</b> <b>Adam Theodore Blentlinger</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Adelaide Murphy</b>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>215- 48- 3228</b>			<b>17. INFORMANT</b> <b>Sheridan Blentlinger-102 E. 4th. St.-</b>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Sensitivity with arteriosclerosis + gangrene</i> <b>4501</b> <b>DOE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>DOE TO</b> <b>(c)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 weeks</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <b>(IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1953</b> , <b>to</b> <b>3-7-1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>2-14-1966</b> , <b>and that death occurred at</b> <b>4A. M.</b> , <b>from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <i>Rex R. Martin</i>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MEO. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>March 7-1966</b>				
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. Rex R. Martin</b>						<b>22d. ADDRESS</b> <b>220 N. Market St.- Frederick-Md. 21701</b>						
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>3-9-1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>			<b>23d. LOCATION</b> (City, town or county) (State) <b>Frederick- Maryland 21701</b>				
<b>24. FUNERAL DIRECTOR</b> <b>M. E. Etchison &amp; Son</b> <i>Elwood T. Whitmore</i>						<b>25a. REC'D BY REGISTRAR</b> <b>MAR 10 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03744 CERTIFICATE OF DEATH 03734										
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN 1b <b>4 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>					d. STREET ADDRESS <b>Clark Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ray</b> First <b>Howard</b> Middle <b>Boarts</b> Last			4. DATE OF DEATH <b>March 19 1966</b> Month <b>March</b> Day <b>19</b> Year <b>1966</b>							
5. SEX <b>male</b>		6. COLOR OF RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-19-07</b>		9. AGE (In years last birthday) <b>59</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Harman Boarts</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Watterman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>			16. SOCIAL SECURITY NO. <b>338-10-4986</b>		17. INFORMANT <b>Corinne K. Boarts</b>			Address <b>Thurmont, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malnutrition, antenatal, postnatal</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 yr +</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 22</b> , 19 <b>66</b> , to <b>Mar 19</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>March 19</b> , 19 <b>66</b> , and that death occurred at <b>7:30</b> A.M., from the causes and on the date stated above.										
22a. SIGNATURE <b>Henry V. Chase</b>								22b. DATE SIGNED <b>19 March 66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>					22d. ADDRESS <b>4E Church St Frederick, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-22-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Thurmont Fred. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond E. Guager</b>					ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MAR 21 1966

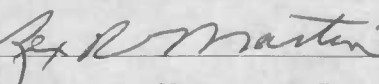

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03745

03735

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <span style="float: right;">b. STATE <b>Maryland</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural</b> <span style="float: right;">d. LENGTH OF STAY IN b. Years <b>10-1</b></span> e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Adamstown, Maryland</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Frederick</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural</b> d. STREET ADDRESS <b>Adamstown, Maryland</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>CHARLES TYSON BRANDENBURG</b>		<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>16</b> Year <b>19 66</b>		<b>5. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>November 22, 1900</b>		<b>9. AGE (in years last birthday)</b> <b>65</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Nr. Urbana, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Martin Brandenburg</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Bussard</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214 28 0631</b>		<b>17. INFORMANT</b> <b>Mrs. Carrie Brandenburg</b> (Same as item #2)			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute leukemia, type unknown.</b> 2043 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3-4 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>9-1-</b> <b>1953</b> <b>to</b> <b>3-16-</b> <b>1966</b> <b>that (I) (we) last saw the deceased alive on</b> <b>3-8-</b> <b>1966</b> <b>and that death occurred at</b> <b>6 p.m.</b> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> 		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>March 17, 1966</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Rex R. Martin, M.D.</b>		<b>22d. ADDRESS</b> <b>220 N. Market Street, Frederick, Maryland</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>March 19, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bush Creek Cemetery</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Monrovia, Maryland</b>		<b>23e. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>MAR 21 1966</b> 					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg,</b>			c. LENGTH OF STAY IN 1b <b>60 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg,</b> <b>10-1</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D.# 1</b>					d. STREET ADDRESS <b>R.D.# 1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Julia Brawner</b>			First Middle Last		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 15, 1884</b>		9. AGE (In years last birthday) <b>81</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emanuel Carbaugh</b>					14. MOTHER'S MAIDEN NAME <b>Mary E. O'Conner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-30-8910</b>		17. INFORMANT Address <b>Mrs. Mary Edith Wagerman, Emmitsburg, Md. R.D. #1</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>260X</b> DUE TO <b>arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Diabetes Mellitus</b> (b) (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>Jan. 1945</b> to <b>March 31, 1966</b> , that (1) (we) last saw the deceased alive on <b>about Jan 15, 1966</b> , and that death occurred at <b>1:10 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>W.R. Cadle</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-1-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>W. R. Cadle</b>					22d. ADDRESS <b>Emmitsburg, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony's Shrine</b>			23d. LOCATION (City, town or county) (State) <b>Emmitsburg, Frederick Co. MD.</b>		
24. FUNERAL DIRECTOR <b>Clarence E. Wilson</b>					ADDRESS <b>Emmitsburg, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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Item 18 Film 375 3-29-66  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**  
03747 03737

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
c. LENGTH OF STAY IN ID <b>Lifetime</b>				d. STREET ADDRESS <b>117 E. 8th. St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BRUCE</b> Middle <b>A.</b> Last <b>BRUCHEY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11- 1916</b>	
9. AGE (in years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>49</b> Days <b>10</b> Hours <b>1</b> Min.		IF UNDER 24 HRS. Hours <b>10</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Adjuster</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bank Credit Dept.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry Charles Bruchey</b>				14. MOTHER'S MAIDEN NAME <b>Lydia M. Strailman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>220-10-5093</b>		17. INFIRMARY Address <b>Frederick-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DEFERRED</b> (b) <b>Gangrene, left leg</b> DUE TO <b>Thrombosis of Vena Cava</b> (c) <b>Mesothelioma Peritoneum &amp; Ascites</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b> <b>10 months</b> <b>20 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2</b> , 19 <b>64</b> , to <b>3/22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/22</b> , 19 <b>66</b> , and that death occurred at <b>4:10</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard C. Reynolds</b>				22b. DATE SIGNED <b>3/22/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds</b>	
22d. ADDRESS <b>804 Toll House Ave.-Frederick-Md. 21701</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>	
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>				25a. REC'D BY REGISTRAR <b>MAR 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTROGRAPH OF DEATH

General Hospital  
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St. Paul, Minn.

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St. Paul, Minn.

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1111 N. 1st St.  
St. Paul, Minn.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03748					03738				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Frederick</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>3 Weeks</b>			d. STREET ADDRESS <b>116 West Third Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <b>ROSA MAIN CAIN</b>					Month Day Year <b>MARCH 29 19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 1, 1876</b>		9. AGE (In years last birthday) yrs. <b>89</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>CHARLES V. MAIN</b>					14. MOTHER'S MAIDEN NAME <b>CLARA ZIMMERMAN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214 10 5906</b>		17. INFORMANT Address <b>Mrs. Frances Shirey, 121 Fairview Ave. Frederick, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4501 Gangrene RT Leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis obliterans</b> (c) <b>2 years</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>general Arterio sclerosis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 16, 1958</b> to <b>Mar 29, 1966</b> that (I) (we) last saw the deceased alive on <b>Mar 29 1966</b> , and that death occurred at <b>1 A.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>Thomas E. Stone</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>March 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M. D.</b>					22d. ADDRESS <b>4 West Third Street, Frederick, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 31, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>		
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03749						03739					
1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> 10-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FREDERICK MEMORIAL</u>						d. STREET ADDRESS <u>RT. # 6</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES E. CRUMMITT</u>			First Middle Last			4. DATE OF DEATH Month Day Year <u>3-16</u> 19 <u>66</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-8-93</u> 72 yrs.		9. AGE (in years last birthday) IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Fredricks, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Crummitt</u>						14. MOTHER'S MAIDEN NAME <u>IDA BENTZ</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>233-05-5969</u>		17. INFORMANT <u>ROTH CRUMMITT</u>			Address <u>RT 6 Fredricks</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cerebral &amp; peripheral vascular disease with past history of multiple cerebral vascular accidents</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>cerebral vascular accidents</u> DUE TO (c) <u>14 years</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-3-</u> 19 <u>66</u> , to <u>3-16-</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-16-</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Rex R Martin</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Rex R Martin MD</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>3-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>			23d. LOCATION (City, town or county) (State) <u>FREDERICK MD.</u>		
24. FUNERAL DIRECTOR <u>SALAMONE FUNERAL HOME FREDERICK, MD.</u>						25a. REC'D BY REGISTRAR <u>MAR 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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037350  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03740

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>210 East Sixth Street</b>	
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>ROBERTA</b> Last <b>DEVILBISS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 10, 1881</b>
9. AGE (in years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Farmer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Shoemaker</b>		14. MOTHER'S MAIDEN NAME <b>Sally Eyler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 10 2742</b>	
17. INFORMANT <b>George Devilbiss</b>		Address <b>Route 6, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarctions, Old &amp; Recent</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fecal Impaction; Ileus</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-13-66</b> , 19__, to <b>3-22-66</b> , 19__, that (I) <del>we</del> last saw the deceased alive on <b>3.22.66</b> 19__, and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Rex R. Martin</b>		22b. DATE SIGNED <b>3.22.66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>		22d. ADDRESS <b>220 N. Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 25, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son, Frederick, Md</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

25a. REC'D BY REGISTRAR  
MAR 24 1966

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>					c. LENGTH OF STAY IN 1b <b>3 Days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>					e. STREET ADDRESS <b>10-1</b>				
3. NAME OF DECEASED (Type or print) <b>Harriet</b> First <b>Ida</b> Middle <b>Ordman</b> Last					4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 29, 1880</b>		9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Hull</b>					14. MOTHER'S MAIDEN NAME <b>Mary Catherine Kriebbaum</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ruth Miller</b> Address <b>Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Degenerative arteriosclerotic Cardiovascular disease</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fractured right hip.</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>66</b> , to <b>3/16</b> , 19 <b>66</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6 PM 3/16 1966</b> , and that death occurred at <b>8:37</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert R. R. Roberts</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert R.R. Roberts</b>						22d. ADDRESS <b>Frederick, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Snydertown Pa.</b>			
24. FUNERAL DIRECTOR <b>Ray C. Gladhill</b>				ADDRESS <b>Middletown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03752					03742						
1. PLACE OF DEATH a. COUNTY <i>Frederick</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frederick</i> c. LENGTH OF STAY IN 1b <i>years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Frederick Memorial Hospital</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frederick</i> d. STREET ADDRESS <i>201 Lindbergh Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Emma Etchison</i>			4. DATE OF DEATH Month <i>March</i> Day <i>30</i> Year <i>1966</i>								
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/4/1900</i>	9. AGE (in years last birthday) <i>65</i> yrs.	IF UNDER 1 YEAR Months <i>6</i> Days <i>5</i> Hours <i>10</i> Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Howard G. Taylor - Sr.</i>			14. MOTHER'S MAIDEN NAME <i>Flora Rippeon</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					
16. SOCIAL SECURITY NO. <i>214-10-3615</i>			17. INFORMANT <i>Mr. Carol L. Etchison</i>			Address <i>Frederick - Md.</i> <i>201 Lindbergh Ave.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> <i>4201</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Cardio-vascular Disease</i>										INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour a.m. _____ p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>March 27, 1966</i> , to <i>March 30, 1966</i> , that (I) (we) last saw the deceased alive on <i>March 30, 1966</i> , and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>A. A. Pearre</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>3/31/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>Dr. A. A. Pearre</i>			22d. ADDRESS <i>4 E. Church St. - Frederick, Md. 21701</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>April 2 - 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Frederick, Md. 21701</i>				
24. FUNERAL DIRECTOR <i>Elwood T. M.R. Etchison &amp; Son</i>			ADDRESS <i>Whitmore</i> <i>Frederick, Md. 21701</i>			25a. REC'D BY REGISTRAR <i>APR 1 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

84824

RECEIVED

1950

*[Faint, mostly illegible text and markings covering the page, including what appears to be a large circular stamp or seal on the right side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 (M)

03753

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND


CERTIFICATE OF DEATH

03743

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Convalescent + Nursing Home</u>				d. STREET ADDRESS <u>Fulton Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIAS EARL HAIFLEIGH</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1966</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 30 1893</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Haifleigh</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-28-6054</u>		17. INFORMANT <u>Mrs. Grayson Haifleigh, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GANGRENE, RIGHT LEG</u> <u>4501</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIO SCLEROSIS, GENERALIZED</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 WEEKS</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>21</u> , 19 <u>66</u> , to <u>3/10</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>3/5</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard C. Reynolds,</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD C. REYNOLDS</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>M. Libertytown, Md.</u>	
24. FUNERAL DIRECTOR <u>Y.C. Barton, Walkersville, Md.</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1234



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
c. LENGTH OF STAY IN 1b <b>26 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		d. STREET ADDRESS <b>417 Brunswick Street</b>	
3. NAME OF DECEASED (Type or print) First <b>MABELLE</b> Middle <b>MARY</b> Last <b>HAMMOND</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1890</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR: Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pleasantville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Adam Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Elizabeth Deitzler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-5234</b>	
17. INFORMANT <b>Mrs. Mary Kronk</b>		Address <b>417 Brunswick St., Brunswick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Automated heart drain</b> DUE TO (c) <b>15 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-18-79</b> , to <b>3-21-66</b> , that I last saw the deceased alive on <b>3-21-66</b> , and that death occurred at <b>12:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b> DATE SIGNED <b>3-22-66</b>			
ACTUAL SIGNATURE <b>L. E. P. Ruff</b>		M.D. <b>Brunswick, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/23/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Samples Manor, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Judge</b>		ADDRESS <b>Harpers Ferry, West Va.</b>	
24a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
MAY 10 1934		BALTIMORE, MARYLAND	
AGE		SEX	
65		M	
RACE		RELIGION	
WHITE		METHODIST	
BIRTH DATE		BIRTH PLACE	
MAY 10 1868		BALTIMORE, MARYLAND	
FATHER'S NAME		MOTHER'S NAME	
JOHN B. BROWN		MARY A. BROWN	
EDUCATION		OCCUPATION	
HIGH SCHOOL		RETIRED	
PREVIOUS ILLNESS		CAUSE OF DEATH	
NONE		HEART DISEASE	
MEDICAL ATTENDANCE		POST-MORTEM	
YES		NO	
NAME OF PHYSICIAN		NAME OF PATHOLOGIST	
DR. J. B. BROWN		DR. J. B. BROWN	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PATHOLOGIST	
<i>J. B. Brown</i>		<i>J. B. Brown</i>	
DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 10 1934		MAY 10 1934	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03755

03745

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>423 N. Bentz Street</b>		d. STREET ADDRESS <b>423 N. Bentz Street</b>	
3. NAME OF DECEASED (Type or print) <b>PAUL EDWARD HIMES, SR.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 15, 1906</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick City</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Jefferson, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Himes</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Metz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 07 8982</b>	
17. INFORMANT <b>Mrs. Clara C. Himes (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-15</b> , 19 <b>65</b> to <b>3-11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-11</b> 19 <b>66</b> , and that death occurred at <b>3A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Stone</b>		22b. DATE SIGNED <b>March 11, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M.D.</b>		22d. ADDRESS <b>4 West Third Street, Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 14, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>MAR 14 1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03756 CERTIFICATE OF DEATH 03746										
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>36 East 6th. St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Franklin</b> Middle <b>J.</b> Last <b>Houff</b>					4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 3-1903</b>		9. AGE (In years last birthday) <b>62</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sanitation Dept.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Michael Joseph Houff - (deceased)</b>					14. MOTHER'S MAIDEN NAME <b>Aletha Viola Renner-(living)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>212- 03- 1311</b>		17. INFORMANT Address <b>Frederick-Md.</b> <b>Mrs. Isabelle Boone Houff-36 E. 6th. St.-</b>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>62</b> , to <b>March</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>March</b> , 19 <b>66</b> , and that death occurred at <b>2:05A</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Dr. LeRoy T. Davis</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Dr. LeRoy T. Davis</b>					22d. ADDRESS <b>Professional Bldg.- Frederick- Md. 21701</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 14-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>			
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>					ADDRESS <b>Baltimore</b>		25a. REC'D BY REGISTRAR <b>MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1950

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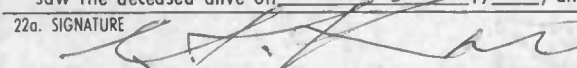

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03757

03747

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>13 Virginia Ave.</b>		d. STREET ADDRESS <b>same</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WILLIAM</b> Last <b>HUTTS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>19 66</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/1899</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	IF UNDER 24 HRS. Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brunswick</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Hutts</b>		14. MOTHER'S MAIDEN NAME <b>Emma Simons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-14-2719</b>	
17. INFORMANT <b>Eugene Hutts</b>		Address <b>Brunswick Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>353.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) <b>Epilepsy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 days</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19, 19 58</b> , to <b>Mar. 30, 19 66</b> , that (I) (we) last saw the deceased alive on <b>Mar. 30, 19 66</b> , and that death occurred at <b>4:15 P. M.</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>Mar. 31, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.T. Byron Kao, M.D.</b>		22d. ADDRESS <b>Gum Spring Hollow Brunswick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>1</b>	23b. DATE THEREOF <b>4/1/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Brunswick Fred. Md.</b>
24. FUNERAL DIRECTOR <b>Funeral Home Brunswick Md.</b>		25a. REC'D BY REGISTRAR <b>APR 4 1966</b>	
25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1933

1933

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Date of registration

11. Name of informant  
12. Address of informant  
13. Signature of informant  
14. Date of statement



1  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

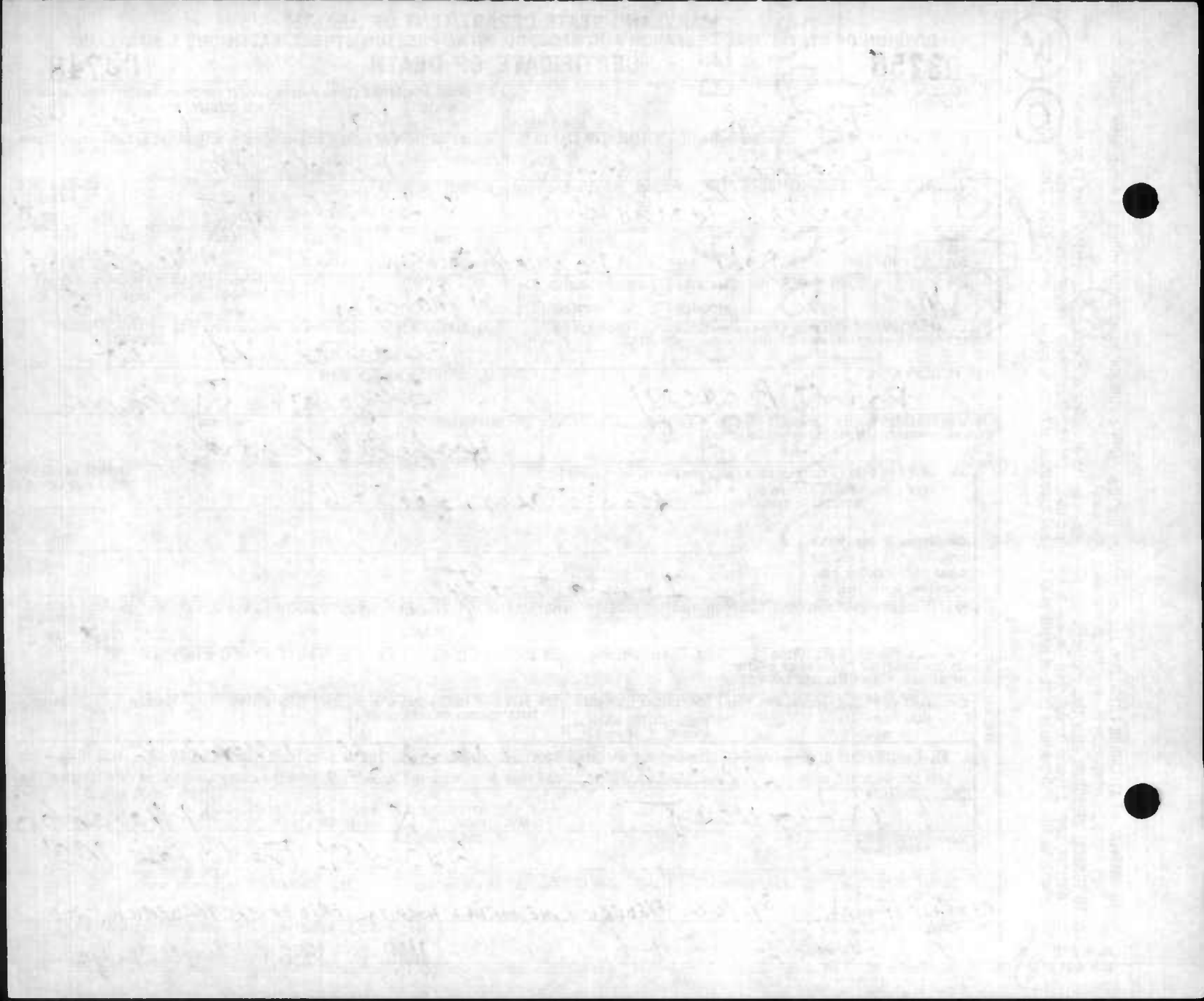
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03758

03748

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 10-1	
c. LENGTH OF STAY IN lb <u>6 hrs</u>		d. STREET ADDRESS <u>4 Lincoln Apts</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robbie Donnell Jackson</u>		4. DATE OF DEATH <u>1 March 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 March '66</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Bracey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>7625</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Astelectasis, foetal</u> DUE TO (b) <u>Immaturity</u> DUE TO (c) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>this hospital</del> attended the deceased from <u>1 March 1966</u> , to <u>1 March 1966</u> , that (I) <del>two</del> last saw the deceased alive on <u>1 March 1966</u> , and that death occurred at <u>2P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R L G West</u>		22b. DATE SIGNED <u>1 March 66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>6 W 3rd St. Frederick Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>RELEASE TO HOSPITAL</u>		23b. DATE THEREOF <u>3/1/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FREDERICK MEMORIAL HOSPITAL</u>		23d. LOCATION (City, town or county) (State) <u>FREDERICK, M.D.</u>	
24. FUNERAL DIRECTOR <u>P. David Youngblat</u>		25a. REC'D BY REGISTRAR <u>MAR 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03759  
CERTIFICATE OF DEATH  
03749

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 Week</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>Rt 6 Fred Co, Md</b>	
3. NAME OF DECEASED (Type or print) <b>Jane NMN Johns on</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>6-9-1902</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Ayers</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No *****</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rebecca Weedon</b> Address <b>Rt 6 Frederick, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1530 Congestive Heart Failure</b> DUE TO (b) <b>Intestinal Obstruction - Small Bowel</b> DUE TO (c) <b>Carcinoma of Cecum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-22</b> , 19 <b>66</b> , to <b>3-2</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>3-2</b> , 19 <b>66</b> , and that death occurred at <b>2:45</b> p.m., from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E Stone</b>		22b. DATE SIGNED <b>3-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas STONE</b>		22d. ADDRESS <b>Frederick, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-5-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bartonsville</b>		23d. LOCATION (City, town or county) (State) <b>Bartonsville Fred. Md</b>	
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111</b>		25a. REC'D BY REGISTRAR <b>Frederick, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 4 1966</b>	

02730

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF OF BUREAU  
PLANT INDUSTRY  
UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
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PLANT INDUSTRY

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
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BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF OF BUREAU  
PLANT INDUSTRY  
UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF OF BUREAU  
PLANT INDUSTRY

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF OF BUREAU  
PLANT INDUSTRY  
UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF OF BUREAU  
PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

(M)

03750  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03750

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Middletown</b> c. LENGTH OF STAY IN 1b <b>40 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Middletown</b> d. STREET ADDRESS <b>W. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Catherine Joy</b> First Middle Last		4. DATE OF DEATH <b>3 12 19 66</b> Month Day Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/7/1904</b> 9. AGE (In years last birthday) <b>61 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>clothing manufacture Fred. Co., Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George W. Slifer</b>		14. MOTHER'S MAIDEN NAME <b>Lilly Catherine Poffenberger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Earl Joy, Middletown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Bent Tissue</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January</b> , 19 <b>66</b> , to <b>2-5-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2-5-</b> , 19 <b>66</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Heurand</b>		22b. DATE SIGNED <b>3-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Secondari</b>		22d. ADDRESS <b>Boonsboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Middletown, Md.</b>	
24. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Items 18, 20&21 Film 0375 4/11/66  
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03761  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03751

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>D O A</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dickerson</b> d. STREET ADDRESS <b>-----</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alda Justus</b>		4. DATE OF DEATH Month Day Year <b>Mar. 22 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/1943</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manual labor</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>22 yrs.</b> IF UNDER 1 YEAR Months Days Hours Min. <b>22 19 66</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lathalt Justus</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Viers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-42-2497</b>	
17. INFORMANT <b>Walter B. Young</b>		Address <b>2804 Wakefield St. Arlington, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>8234 Fractured skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Lacerated brain</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <b>H</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Was passenger in car that struck tree</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>1:20 a.m. 3/22 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Dickerson</b>		20f. (City or town) (County) (State) <b>Dickerson Montgomery Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED	
23b. DATE THEREOF <b>3/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	
23d. LOCATION (City, town or county) (State) <b>Beallsville Md.</b>		23a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
24. FUNERAL DIRECTOR <b>Constance C. Hilton</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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Item 20 Film G375 4/4/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03762 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03752

1. PLACE OF DEATH  
a. COUNTY Frederick MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick  
c. LENGTH OF STAY in 1b 2 Days  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)  
a. STATE Maryland  
b. COUNTY Frederick  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beallsville  
d. STREET ADDRESS  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last  
LAWSON JUSTUS  
4. DATE OF DEATH Month Day Year  
MARCH 26 1966

5. SEX Male  
6. COLOR OR RACE White  
7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH April 25, 1934  
9. AGE (In years last birthday) 31 yrs.  
IF UNDER 1 YEAR Months Days  
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseryman  
10b. KIND OF BUSINESS OR INDUSTRY Green Hill Nursery  
11. BIRTHPLACE (State or foreign country) Beallsville, Md. Hurley, Va.  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Burel C. Justus  
14. MOTHER'S MAIDEN NAME Powley Justus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes  
16. SOCIAL SECURITY NO. 57 to 59 230 36 9727  
17. INFORMANT Hospital Records. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Fractured Skull, Crushed Chest  
8234 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lacerated Brain  
DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran off the road into a tree.  
20c. TIME OF INJURY Month, Day, Year Hour Minute p.m. 3/22 19 66  
20d. INJURY OCCURRED While ☐ Not While ☒ el work  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road  
20f. (City or town) (County) (State) Nr. Dickerson Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ACTUAL SIGNATURE B.O. Thomas M.D. ASSISTANT MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) B.O. Thomas Sr. M.D. DEPUTY MEDICAL EXAMINER ☒  
Address (Street, city, town, or county) DATE SIGNED 3-27-66

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
22b. DATE THEREOF March 31, 1966  
22c. NAME OF CEMETERY OR CREMATORY Justus Cemetery  
22d. LOCATION (City, town, or county) (State) Hurley, Va.

23. FUNERAL DIRECTOR M.R. Etchison & Son, Frederick, Maryland ADDRESS  
24a. REC'D BY REGISTRAR MAR 29 1966  
24b. REGISTRAR'S SIGNATURE J. Charles Judge

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PV-3, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03763 CERTIFICATE OF DEATH 03753

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>THURMONT - RURAL</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>FREDERICK MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THELMA ELIZABETH KERSEY</b>			4. DATE OF DEATH Month Day Year <b>MARCH 31 1966</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-20-07</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>HARRY M ISANOGLE</b>			
14. MOTHER'S MAIDEN NAME <b>ELIZABETH EICHELBERGER</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>216-05-5604</b>				17. INFORMANT <b>BESSIE M. MARTIN</b> Address <b>Thurmont, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> <b>1750</b> DUE TO (b) <b>CARCINOMA OF OVARY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>12 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> , 1966, to <b>3-31</b> , 1966, that (I) (we) last saw the deceased alive on <b>MAR 31 1966</b> , and that death occurred at <b>6:40</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>John M. Culler</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-31-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN M. CULLER</b>				22d. ADDRESS <b>15 E 2ND ST. FREDERICK, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-4-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Thurmont Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Egan</b>				ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 6 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film G375 4/2/66  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03764  
MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
03754

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b> d. STREET ADDRESS <b>Route #3, Frederick</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Mamie First F. Middle Kidd Last</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 66</b>							
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1882</b>	9. AGE (In years last birthday) <b>83</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Harmony, Frederick, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Sampson Young</b>		14. MOTHER'S MAIDEN NAME <b>Samantha Baker</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Lloyd L. Hoover (Same as item #2)</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b> (c) <b>Arteriosclerotic and chronic rheumatic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yr.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephrosclerosis</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 14, 1958</b> , to <b>Mar 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>Mar 26, 1966</b> , and that death occurred at <b>8:00</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Thomas E Stone</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-26-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Thomas Stone</b>		22d. ADDRESS <b>Frederick MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>			
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24b. ADDRESS <b>Frederick</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

03765

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03755

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>806 East Patrick Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MILDRED</b> Middle <b>LORRAINE</b> Last <b>LACIAK</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>3</b> Year <b>19 66</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov. 18, 1917</b>
<b>9. AGE</b> (In years last birthday) <b>48 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick, Maryland</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Dennis LeRoy Brightwell (D)</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Ida May Smith (D)</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>XXXXXXXXXX 220/10/5519</b>		<b>17. INFORMANT</b> <b>Mr. Adolph T. Laciak</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with congestive heart failure</b> 287X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchitis, subacute</b> DUE TO (c) <b>Obesity</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 1/2 mo. years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 11-4-1952 to 3-3-1966; that (I) (we) last saw the deceased alive on 3-3-1966, and that death occurred at 10:30 M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Dr. Rex R. Martin</b>		<b>22b. DATE SIGNED</b> <b>March 3, 1966</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Rex R. Martin</b>		<b>22d. ADDRESS</b> <b>220 North Market Street Frederick, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/7/1966</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mount Olivet Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Frederick, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert E. Dailey &amp; Son</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 8 1966</b>	
<b>ADDRESS</b> <b>Frederick, Maryland</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

CERTIFICATE OF DEATH

03750

Frederick

Frederick

Frederick

Frederick

Frederick Memorial Hospital

Frederick Memorial Hospital

Frederick Memorial Hospital

Nov. 10, 1917

Nov. 10, 1917

Frederick, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN ID <b>Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b> d. STREET ADDRESS <b>Walter Martz Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>WALTER</b> First <b>CLAYTON</b> Middle <b>MARTZ</b> Last			4. DATE OF DEATH <b>March</b> Month <b>23</b> Day <b>19</b> Year <b>66</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 9, 1897</b>		9. AGE (In years last birthday) <b>69</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Farmer</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Clayton Martz</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Craver</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>215 36 7278</b>		17. INFORMANT <b>Walter A. Martz, Yellow Springs, Md.</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.V.D.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1966</b> to <b>March 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 23, 1966</b> , and that death occurred at <b>6:35 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Bernard D. Thomas Jr.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 23, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>B.D. Thomas Jr. M.D.</b> <b>L.T. Davis, M.D.</b>					22d. ADDRESS <b>228 North Market Street, Frederick, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>March 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>		
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MAR 28 1966

4. 10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03767					03757						
Item 1d Film 4272 3/23/66					Item #2 Film 0376 5/12/68						
1. PLACE OF DEATH a. COUNTY		Frederick			MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE			Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick			27 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					Frederick Memorial Hospital					d. STREET ADDRESS Md. Odd Fellows Home	
3. NAME OF DECEASED (Type or print)		Josephine			J. Mathew		4. DATE OF DEATH		Mar. 19 1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 17-1885		80 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Retired R.N.		Institutional Nurse		Lynchburg- Va.		U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Not available					Not available						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		Arlington-Va.			
No		577-16-0630		Mrs. Louise Burke-134 N. Oakland St.-							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Glaucoma, bilateral</u>										INTERVAL BETWEEN ONSET AND DEATH 3 mo 5 yrs +	
20a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
				19							
21. I certify that (I) (this hospital) attended the deceased from <u>28 Dec</u> , 19 <u>65</u> , to <u>19 Mar</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>18 March</u> 19 <u>66</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry V. Chase</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 19 March 66	
22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>						22d. ADDRESS <u>4 E. Church St Frederick, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		March 22-66		Mt. Olivet Cemetery		Frederick- Md.		21701			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<u>Elwood T. M.R. Etchison &amp; Son</u>		Frederick-Md. 21701		MAR 22 1966		<u>J. Charles Judge</u>					

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03768

03758

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Jefferson</b> c. LENGTH OF STAY IN lb <b>1 year</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Jefferson</b> d. STREET ADDRESS <b>16-1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jean Elizabeth Mentzer</b>				4. DATE OF DEATH Month Day Year <b>3 13 19 66</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/8/1939</b>	
9. AGE (In years last birthday) <b>27 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>clothing manufacture Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Alvin Miller</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Staubs</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-34-9612</b>		17. INFORMANT <b>Robert L. Mentzer, Jefferson, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Transsection of Aorta, Laceration of Spleen, Liver, Pancreas, Kidney, Stomach Bowel</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shot gun Wound of Lower Chest</b> DUE TO (c) <b>Shotgun Wound of Lower Chest</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot self in chest</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in chest</b>			
20c. TIME OF INJURY Hour <b>7:30</b> p.m. Month, Day, Year <b>3-13-66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Burbitonville-Frederick-Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B.O. Thomas</b>				DATE SIGNED <b>3-14-66</b>			
EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Frederick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>3/16/66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Locust Valley Ch. of God</b>	
23. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Md.</b>				22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>		24. REC'D BY REGISTRAR <b>MAR 16 1966</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

**Figure 4**      **a)**

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03769  
CERTIFICATE OF DEATH  
03759

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>22 Winchester St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Irving</b> Last <b>Michael</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1st.</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15- 1899</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. UNDER 1 YEAR Months <b>66</b> Days <b>19</b>		11. UNDER 24 HRS. Hours <b>19</b> Mins. <b>66</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miller</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Flour Mill</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>	
13. FATHER'S NAME <b>Samuel Curtis Michael</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frances Williams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-10-2876</b>		17. INFORMANT <b>Mrs. Raymond Boyles-22 Winchester St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA HEAD of PANCREAS</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/27</b> , 19 <b>65</b> , to <b>3/1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/1</b> , 19 <b>66</b> , and that death occurred at <b>8:45</b> P.M. from the causes and on the date stated above.				22b. DATE SIGNED <b>3/1/66</b>			
22a. SIGNATURE <b>John H. Teske</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <b>Dr. John H. Teske</b>	
22d. ADDRESS <b>700 Montclair Ave.-Frederick, Md. 21701</b>				22e. ADDRESS <b>700 Montclair Ave.-Frederick, Md. 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 5-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>	
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son---</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE <b>MAR 4 1966</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03770 CERTIFICATE OF DEATH 03760									
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick Days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Buckeystown 10-1 d. STREET ADDRESS Buckeystown, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ERNEST First Middle Last 4. DATE OF DEATH March 26 19 66 Month Day Year			5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 29, 1886 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR: Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Self Employed 11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Mogg 14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT George P. Mogg, Buckeystown, Maryland Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myelocytic Leukemia 2041 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Nov. 1966, to Mar. 26, 1966, that (I) (we) last saw the deceased alive on March 26 1966, and that death occurred at 8:40 P.M. from the causes and on the date stated above.									
22a. SIGNATURE W. J. Reddick 22c. PHYSICIAN'S NAME (Type) W. J. Reddick, M. D.					22b. DATE SIGNED Mar. 26, 1966 22d. ADDRESS Frederick Medical Center, Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 30, 1966 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery 23d. LOCATION (City, town or county) (State) Frederick, Maryland			24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. ADDRESS 25a. REC'D BY REGISTRAR MAR 31 1966 25b. REGISTRAR'S SIGNATURE Charles Judge						

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03771

03761

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural- Ijamsville</b> <span style="float: right;">c. LENGTH OF STAY IN lb <b>Lifetime</b></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Frederick</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Ijamsville</b> d. STREET ADDRESS _____					
<b>3. NAME OF DECEASED</b> (Type or print) <b>William Maynard Montgomery</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>March 1- 19 66</b> Month Day Year					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 29-1884</b> 81 yrs.		<b>9. AGE</b> (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>George Wilson Montgomery</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Elizabeth Crawford</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>Mr. Rayner Montgomery-</b> <span style="float: right;">Address <b>Near Frederick, Md.</b></span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> 4500 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 years +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Immobility due to old hip dislocation</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19 ____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1966 to Mar. 1, 1966 that (I) (we) last saw the deceased alive on Mar. 1, 1966, and that death occurred at 2:20 p.m. on the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>W. J. Riddick, M.D. for J. R. Poirier, M.D.</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. J.R. Poirier or Dr. W.J. Riddick</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>March 2-1966</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>March 3-1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) <b>Frederick, Md.</b> <b>(State)</b> <b>21701</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M.R. Etchison &amp; Son</b> <b>Frederick, Md. 21701</b>						<b>25a. REC'D BY REGISTRAR</b> <b>MAR 4 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03772 CERTIFICATE OF DEATH 03762											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN lb <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick/Mem. Hospital</b>						d. STREET ADDRESS <b>9715 Beall Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>Dr. Frederick N. Oden</b>						4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1885</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Signal maintainer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Melvin A. Oden</b>						14. MOTHER'S MAIDEN NAME <b>Mary Kanode</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>John R. Oden, Kensington, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <b>Arteriosclerotic Heart Disease with Congestive Failure</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 11, 1966</b> , to <b>March 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1966</b> , and that death occurred at <b>6:40 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>A. A. Pearre</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/13/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. A. Pearre, M.D.</b>						22d. ADDRESS <b>Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>				23d. LOCATION (City, town or county) (State) <b>Frederick, Md.</b>			
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>						25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03763**

**1** **(M)**  
FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Frederick)</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt 4 Frederick, Md</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b> d. STREET ADDRESS <b>Rt 4 Frederick</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>John Thomas Offord</b>				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>14</b> Year <b>19 66</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10/21/1899</b>		<b>9. AGE</b> (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Canning Factory</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>*****</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Fred Co, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Richard Offord</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Lucy English</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>*****</b>		<b>17. INFORMANT</b> <b>Lola Hall</b> Address <b>Frederick, Md</b> <b>160 W. All Saints St</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (c) <b>Diabetes Melitus</b> (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></b>									
<b>ACTUAL SIGNATURE</b> <i>B. O. Thomas</i>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <i>B. O. Thomas, MD</i>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>3/14/1966</b>	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>3/17/1966</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Hopehill</b>		<b>22d. LOCATION (City, town, or county)</b> <b>(State)</b> <b>Frederick Co. Md</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C.E. Hicks, III</b>				<b>ADDRESS</b> <b>Frederick, Md</b>		<b>24a. REC'D BY REGISTRAR</b> <b>MAR 16 1966</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1938

Form with multiple sections for medical examination, including fields for name, date, time, and location. The form is divided into several columns and rows, with various checkboxes and text areas for recording medical findings and death details.

NAME: [Blank]

DATE: [Blank]

TIME: [Blank]

LOCATION: [Blank]

CAUSE OF DEATH: [Blank]

... [Additional fields and checkboxes follow in a structured layout]

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03774 1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>					03764 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>213 E. 7th. St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Edward Summerfield Rice</b>			First Middle Last		4. DATE OF DEATH <b>March 12- 19 66</b>		Month Day Year				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 7- 1888</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Olin Rice</b>					14. MOTHER'S MAIDEN NAME <b>Emma Rice</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>212- 05- 0814</b>		17. INFORMANT <b>E. Bryan Rice</b>		Address <b>318 Park Ave.-Frederick-Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <b>6 hours,</b> <b>3 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>68</b> to <b>March 12</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>March 12</b> 19 <b>66</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>LeRoy T. Davis</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 12, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. LeRoy T. Davis</b>						22d. ADDRESS <b>Professional Bldg.- Frederick- Md. 21701</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 15-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>			
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son--</b>				ADDRESS <b>Whitmore Frederick, Md. 21701</b>				25a. REC'D BY REGISTRAR <b>MAR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

05204

05204



Extremely faint, mostly illegible text covering the page, appearing to be a document or report. The text is mirrored across the page, suggesting a bleed-through from the reverse side. Some faint words like "Procedural", "Medical", and "Physical" are visible. At the bottom, there is a date stamp: "MAR 14 1966".

FOR STATE  
HEALTH DEPT.

Item 18 Film G375 4/4/66  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03775 03765

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Pleasant</b> c. LENGTH OF STAY IN b <b>1 1/2 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mt. Pleasant</b> d. STREET ADDRESS <b>Route #1 Frederick</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Earl Calvin Ropp</b>				4. DATE OF DEATH Month Day Year <b>March 17 1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 30, 1922</b>	
9. AGE (In years last birthday) <b>43 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Middletown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Franklin Ropp</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Walters</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-5929</b>		17. INFORMANT Address <b>Mrs. Betty Jane Ropp Frederick, Md. #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Defered / Deceased</b> <b>5811</b> DUE TO <b>Fatty Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Autopsy Results</b> DUE TO <b>Chronic Alcoholic</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B.O. Thomas</b> EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3-18-66</b> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 21, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown Md.</b>	
23. FUNERAL DIRECTOR <b>Paul F. Bittle</b> ADDRESS <b>Myersville, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 28 1966</b> 24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





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64  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03776  
CERTIFICATE OF DEATH  
03766  
Item 2 Information from birth cert.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> 10-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FREDERICK MEMORIAL HOSP</b>			d. STREET ADDRESS <b>Route #5, Edgemont Rd.</b>		
3. NAME OF DECEASED (Type or print) First <b>ELAINE</b> Middle <b>DENISE</b> Last <b>SAXON</b>			4. DATE OF DEATH <b>MAR 1 1966</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 MAR 66</b>	9. AGE (In years last birthday) <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>
13. FATHER'S NAME <b>WILLIAM SAXON</b>			14. MOTHER'S MAIDEN NAME <b>CONSUELO HERNANDEZ</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY ATELECTASIS</b> 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>IMMATUREITY</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1 Mar 1966</b> to <b>1 Mar 1966</b> that (I) (we) last saw the deceased alive on <b>1 Mar 1966</b> and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>F.J. Helonick</b>			22b. DATE SIGNED <b>1 Mar 66</b>		
22c. PHYSICIAN'S NAME (Type) <b>F.J. Helonick</b>			22d. ADDRESS <b>Frederick, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>3/1/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FREDERICK MEMORIAL HOSPITAL</b>	23d. LOCATION (City, town or county) (State) <b>FREDERICK M.D.</b>		
24. FUNERAL DIRECTOR <b>J. David Youngdale</b>			25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

1  
(M)

03777

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03767

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Mem. Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Market</b> d. STREET ADDRESS <b>10-1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Eliza Wright</b>		First Middle Last		4. DATE OF DEATH <b>March 21 19 66</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 16, 1884</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Market, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel R. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Jessie W. Shipley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-50-7753</b>		17. INFORMANT Address <b>Charles W. Wood, New Market, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1965</b> , to <b>3/21, 1966</b> , that (I) (we) last saw the deceased alive on <b>3/21 1966</b> , and that death occurred at <b>8 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James B. Thomas</b>				22b. DATE SIGNED <b>3/22/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>James B. Thomas, M.D.</b>				22d. ADDRESS <b>Professional Bldg. Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>New Market, Md.</b>	
24. FUNERAL DIRECTOR <b>L.K. Falconer</b>				25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

64

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BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont rural</u> d. STREET ADDRESS <u>RD 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edna B. Shank</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>March 1 1966</u> Month Day Year		<b>5. SEX</b> <u>Female</u>			<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
<b>8. DATE OF BIRTH</b> <u>Sept. 17, 1894</u>			<b>9. AGE</b> (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>William Baxter</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Henrietta Snapp</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <u>216-46-6589</u>			<b>17. INFORMANT</b> <u>W.O. Shank</u>			<b>Address</b> <u>Thurmont, Md. RD 1</u>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic heart disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>4-5 yrs</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 1960</u> , <b>to</b> <u>Mar 1, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Mar 1 1966</u> , <b>and that death occurred at</b> <u>10:30</u> <b>M, from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <u>Henry V. Chase</u>								<b>22b. DATE SIGNED</b> <u>1 March 66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Henry V. Chase</u>		
<b>22d. ADDRESS</b> <u>4 E. Church St Frederick, Md</u>								<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22f. ATTENDING PHYS.</b> <input checked="" type="checkbox"/>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>3-4-66</u>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. View Cemetery</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Emmitsburg Fred. Co. Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Raymond E. Guagn</u>						<b>ADDRESS</b> <u>Thurmont, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>MAR 3 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>	

## RESUME

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

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Table 1

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03779

03769

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>404 Thomas Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>404 Thomas Avenue</b> g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>HELEN</b> First <b>RUTH</b> Middle <b>SHOOK</b> Last		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>9</b> Year <b>19 66</b>					
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov. 26, 1910</b>	<b>9. AGE (In years last birthday)</b> <b>55</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>9</b> Days <b>19</b>	<b>IF UNDER 24 HRS.</b> Hours <b>6</b> Min. <b>5</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Irving Chester Knill</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mayme Myrtle Fogle</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-34-9568</b>		<b>17. INFORMANT</b> <b>Mr. Jacob M. Shook</b>		<b>Address</b> <b>404 Thomas Ave. Fred. Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Metastatic Carcinoma of pancreas</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 mos.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, lectory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Frederick, Maryland</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from August 20, 1965 to Mar 9, 1966, that (I) (we) last saw the deceased alive on Mar 9, 1966, and that death occurred at 7:00 M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> 		<b>22b. DATE SIGNED</b> <b>3/9/1966</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Gilcin F. Meadors</b>			
<b>22d. ADDRESS</b> <b>810 Toll House Avenue Frederick, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/12/1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mount Olivet Cemetery</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Frederick, Maryland</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> 		<b>ADDRESS</b> <b>Frederick, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 11 1966</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> 							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1911

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03780

03770

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b.  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Mem. Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Frederick</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Walkersville</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>James</b> Middle <b>Henry</b> Last <b>Smith</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>13</b> Year <b>1966</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 20, 1899</b>	<b>9. AGE</b> (In years last birthday) <b>67</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick Co., Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Pradley Smith</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Lillian Houck</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-44-4138</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Clarence Smith, Mt. Airy, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic lymphatic leukemia</b> <b>2040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3/8</b> , 19 <b>66</b> , <b>to</b> <b>3/13</b> , 19 <b>66</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>3/12</b> , 19 <b>66</b> , <b>and that death occurred at</b> <b>2:30</b> M, <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>James B. Thomas</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>Mar. 13, 1966</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>James B. Thomas, M.D.</b>		<b>22d. ADDRESS</b> <b>Professional Bldg. Frederick, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>March 16, 1966</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Glade</b>	<b>23d. LOCATION (City, town or county)</b> <span style="float: right;">(State)</span> <b>Walkersville, Md.</b>				
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Olin L. Mohan</b>			<b>ADDRESS</b> <b>Damascus, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 21 1966</b>		
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03770

CERTIFICATE OF DEATH

Registration

Date of Death

Age

Sex

Place of Birth

Place of Death

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1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03781-

03771

1. PLACE OF DEATH e. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Virginia</b> b. COUNTY <b>Loudoun</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN It		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Lovettsville 83-3</b>		d. STREET ADDRESS <b>Route 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Katie Waters Stevens</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Oct. 3, 1883</b>	9. AGE (in years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Americus Wenner</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Frazier</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>229-60-5892</b>		17. INFORMANT <b>Catherine Stevens, Lovettsville, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition &amp; Sarcopenia</b> <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Melanotic Carcinoma</b> DUE TO (c) <b>Primary Site undetermined</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b> <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Clearance of generalized Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>June 1965</b> to <b>MARCH 17, 1966</b> that (I) (we) last saw the deceased alive on <b>MARCH 16, 1966</b> , and that death occurred at <b>4:15</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. A. Talbott Brice</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>MARCH 17, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. Talbott Brice</b>				22d. ADDRESS <b>Jefferson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lovettsville, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Etchison &amp; Son, Frederick, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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UNITED STATES DEPARTMENT OF THE INTERIOR  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

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03782

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03772

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Nursing &amp; Conv. Center</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>510 Fairview Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEWIS Edward</b> First Middle Last <b>E. L. THOMPSON</b>		4. DATE OF DEATH <b>March 12, 1966</b> Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 5, 1907</b> May 1977	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Brunswick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Raymond Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Shores</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705 074176</b>	
17. INFORMANT <b>Mrs. Louise F. Thompson (Same as item # 2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema &amp; Uremia</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Coronary Occlusions</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b> <b>6 yrs</b> <b>1964</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June, 1965</b> to <b>Mar 13, 1966</b> that (I) (we) last saw the deceased alive on <b>3/12 1966</b> , and that death occurred at <b>3 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Talbott Brice</b> M.D.		22b. DATE SIGNED <b>March 13, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Talbott Brice, M.D.</b>		22d. ADDRESS <b>Jefferson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 15, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>MAR 16 1966</b>	
25b. REGISTRAR'S SIGNATURE			

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03788 CERTIFICATE OF DEATH 05773

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattstown</b> c. LENGTH OF STAY IN 1b <b>10 - 1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattstown</b> d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Horine Washburn</b>		4. DATE OF DEATH <b>March 31- 19 66</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 9- 1898</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edwin M. Horine</b>		14. MOTHER'S MAIDEN NAME <b>Minerva C. Dudrow</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-07-6527</b>		17. INFORMANT <b>Floyd H. Horine- Hyattstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Complete Heart B lock</b> DUE TO (c) <b>Arteriosclerosis &amp; Arterioscl. Ht. Dis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>few minute</b> <b>1 year</b> <b>Many years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 10, 1965</b> to <b>Mar 31, 1966</b> , that (I) <b>last</b> saw the deceased alive on <b>Mar 31, 1966</b> , and that death occurred at <b>9:55 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Dr. G. F. Meadors</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Apr. 1-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. G. F. Meadors</b>		22d. ADDRESS <b>810 Toll House Ave.- Frederick-Md. 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 3-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christian Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Hyattstown- Md.</b>					
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>		ADDRESS <b>Frederick, Md. 21701</b>		25a. REC'D BY REGISTRAR <b>APR 6 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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Resident: [illegible] [illegible] [illegible]

Occupation: [illegible]

Address: [illegible] [illegible] [illegible]

Phone: [illegible]

Birth: [illegible]

Marital Status: [illegible]

Education: [illegible]

Employment: [illegible]

Religion: [illegible]

Other: [illegible]

Remarks: [illegible]

Signature: [illegible]

Date: [illegible]

Place: [illegible]

Notes: [illegible]

Comments: [illegible]

Additional Information: [illegible]

Final Remarks: [illegible]

Signature: [illegible]

Date: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>Box 171</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick Buckleystown</u> d. STREET ADDRESS <u>Box 171</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Frances Weedon</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6/30/78</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>87</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>James Franklin Lee</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Brown</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>220-03-5083</u> <b>17. INFORMANT</b> <u>Alfred C. Weedon</u> <b>Address</b> <u>Frederick Rt. 2, Md</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR</u> DUE TO (c) <u>Disease</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (1) (this hospital) attended the deceased from</b> <u>3/14</u> , 19 <u>66</u> , <b>to</b> <u>3/21</u> , 19 <u>66</u> , <b>that (1) (we) last saw the deceased alive on</b> <u>3/21</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>9:15</u> <b>PM</b> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Robert J. Thomas</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MEO. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert J. Thomas</u>						<b>22d. ADDRESS</b> <u>812 TOLL HOUSE AVE</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/25/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hopewell</u>				<b>23d. LOCATION (City, town or county)</b> (State) <u>Frederick Co</u> <u>MD</u>			
<b>24. FUNERAL DIRECTOR</b> <u>C.E. Hicks III</u> <u>Frederick, Md</u>						<b>25a. REC'D BY REGISTRAR</b> <u>MAR 24 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03785					03775				
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural</b> d. STREET ADDRESS <b>Route 6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EDITH</b>			First Middle Last <b>IRENE WINPIGLER</b>			4. DATE OF DEATH <b>March 2 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 8, 1903</b>		9. AGE (In years last birthday) <b>62 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Samuel Nusbaum</b>					14. MOTHER'S MAIDEN NAME <b>Ella May Rippeon</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>213 12 4199</b>		17. INFORMANT <b>Mrs. Robert Levering, Route 6, Frederick, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>Essential hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>72 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9/6, 1965</b> to <b>3/2, 1966</b> , that (I) (we) last saw the deceased alive on <b>3/2, 1966</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>James B. Thomas</b>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 3, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>James B. Thomas, M.D.</b>					22d. ADDRESS <b>228 N. Market Street, Frederick, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 5, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick County, Maryland</b>			
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>Charles Judge</b>				
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					DATE <b>MAR 7 1966</b>				

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Dr. Robert A. H. ...